Revisiting Gibson's Guest Editorial on "Minority Aging Research: Opportunity and Challenge" Twenty Years Later: A Tribute

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Abstract

In a 1989 editorial commemorating the Gerontological Society of American's Task Force on Minority Issues, Dr. Rose Gibson, former editor of The Gerontologist and faculty associate of the Program for Research on Black Americans, challenged gerontological researchers to draw fewer majority-minority comparisons and more inter- and intra-group comparisons; to use a life course perspective; to address questions focusing on strengths rather than deficits; and to explore and test standardized measures' validity for their relevance and applicability. To assess progress since Gibson's 1989 editorial to 2007, we searched article titles and abstracts published in The Gerontologist and the Journals of Gerontology Series B: Psychological and Social Sciences by keyword. This article provides a snapshot of how far gerontological research in the aforementioned journals has come in meeting the challenges in conducting research on minority groups that Gibson identified.

In a 1989 editorial commemorating the Task Force on Minority Issues (TFMI), Rose Gibson challenged researchers to draw fewer majority-minority comparisons and more inter- and intra-group comparisons; to use a life course perspective; to address questions focusing on strengths rather than deficits; and to explore and test standardized measures' validity for their relevance and applicability. In marking the 20th anniversary of the TFMI and Gibson's editorial, we provide a snapshot of how far gerontological research has come in meeting these challenges for selected minority

groups, as regards the Society's key goal, to increase quantity and quality of research on minority aging questions.

To assess progress since Gibson's 1989 editorial to 2007, we searched article titles and abstracts published in *The Gerontologist* and the *Journals of Gerontology Series B: Psychological and Social Sciences* by keyword. After counting articles relating to five minority groups (African American, Asian American and Pacific Islander, Hispanic, Native American, and Arab American), we assessed publication quality regarding four key issues presented in Gibson's editorial: (1) methods of group comparison, (2) theoretical base, (3) deficits versus strengths, and (4) measurement standardization.

With respect to quantity, we identified 344 articles pertaining to minority aging between January 1989 and July 2007 for African Americans (n=223), Hispanics (n=76), Asian Americans (n=31), Native Americans (n=13), and Arab Americans (n=1). While there was an upward trend involving African Americans and Hispanics, it wasn't until the mid 2000s that a similar trend appeared for Asian Americans and Native Americans. We identified only one article published between 1989 and July 2007 on Arab American older adults; this article commented on the dearth of research about this group. While progress has been made in increasing the quantity of research published per year, it varies across groups across time.

Regarding quality, the fourth issue considered, measurement standardization, was the most difficult to assess because researchers used various methodologies and were often unclear regarding whether measures were standardized to a majority or target group. In general, this trend persisted across groups. We direct our discussion to reporting trends for the remaining three issues: group comparisons, theoretical framework and deficits versus strengths.

Despite Gibson's recommendation, majority-minority group comparisons prevailed across groups, most notably between African Americans and Caucasians—the majority group. Similarly, most comparisons involving Hispanics and other groups were

also majority-minority with some inter-group but no intra-group comparisons. Furthermore, nearly all articles comparing Caucasian and Hispanic older adults compared another racial/ethnic group, most often African Americans. Articles on Asian American older adults were roughly split on majority-minority group comparisons and inter-group comparisons, with inter-group comparisons involving Caucasian and another racial/ethnic group. Despite the diversity of the Asian American population, we identified only one article using an intra-group comparison model. Most articles targeting Native Americans included group comparisons, and the most common ones were the majority-minority group model followed by inter-group and intra-group comparisons.

Regarding the theoretical base, sociological and life course perspectives prevailed slightly across all groups except African Americans. Among articles on African American older adults, the problem-centered focus was slightly more prevalent. For Hispanics, Asian Americans and Native Americans, nearly half of articles used a sociological perspective as opposed to a problem-centered focus or neither.

Emphasis on deficits outweighed emphasis on strengths across all groups, except for Asian Americans. We found a trend for an emphasis on deficits to be less pronounced for Native Americans than for African American and Hispanic groups.

Overall, we find considerable progress in the quantity and quality of minority aging research since Gibson's editorial. Although progress should be acknowledged and celebrated, findings also indicate need for further steps.

First, we reiterate Gibson's argument that racial and ethnic groups should be researched apart from majority-minority group comparisons. As Gibson acknowledged that broader racial and ethnic groups are not monolithic, we too recommend that diversity be explored within groups. Researchers considering either within-group or between group comparisons may benefit from Whitfield

and colleagues' (2008) study that examined complexities and merits of both designs.

Second, there is opportunity for improvement, particularly among African American populations, for greater representation of sociological and life course perspectives. Perspectives acknowledging the complex relationships among history, culture, health, race, and social institutions including racism ought to be the accepted norm. As the theoretical base informing research was not always well-described, illustrated and referenced, we further recommend the research community require that research is designed according to well-defined frameworks.

Third, the language of deficits and shortcomings continues to pervade research on racial and ethnic groups, thereby suggesting an opportunity to acknowledge group strengths and resources simultaneously in future research. Many of the articles examining deficits recognized the social systems, namely those reinforcing discrimination and inequity, contributing to those shortcomings. We commend this effort and recommend that it define future research.

Fourth, consonant with Gibson's editorial, we recommend that measures be tested on the target population and validity and reliability confirmed, while knowing a significant barrier to using appropriate measures for target populations may concern recruitment issues involving minority groups in research. Aside from the Asian American population, qualitative research is not well-represented. Qualitative research provides an opportunity to increase knowledge of life course effects and construct richer and more detailed measures to understand the experience of aging among diverse groups.

Fifth, adequately assessing real progress requires clear language and terms, namely the definition of minority group. Gibson's editorial lacked a clear definition of minority group, a term more implicitly than explicitly defined in Gibson's editorial and others (e.g., Gibson & Stoller, 1998; Groger, 1998; Markides, 1998). We recommend that clearer language is used in defining minority

group, as this term's sociological meaning may offer opportunity to investigate other social categories than race and ethnicity.

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Rose C. Gibson, Ph.D., was faculty associate in the Program for Research on Black Americans from the late 1970s through 1996; she was Editor-in-Chief of *The Gerontologist*, a journal of The Gerontological Society of America, from 1993-1996.

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Depression in African American Males

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Abstract

Many African American men are burdened by depression due to unique stressors including racism and discrimination, educational attainment, occupational status, income, and poverty. The prevalence of depression and poor mental health outcomes for African American men is quickly approaching a public health crisis, as evidenced by their increasing rate of suicide. Unfortunately, research focusing on addressing the needs of African American men is scarce. The purpose of this literature review is to: 1) highlight the prevalence of depression among African American men; 2) examine risk factors for depression among this group; 3) examine treatment-seeking and coping behaviors; and 4) examine barriers to treatment-seeking. Finally, we discuss implications for future research, mental health care, and outreach with the goal of stimulating interest in addressing depression among African American men.

Introduction

African Americans are the second largest minority population in the U.S., making up approximately 13.4%, or roughly 40.7 million people (U.S. Census Bureau, 2008). Unfortunately, an estimated 7.5 million African Americans suffer from a diagnosed mental illness. When African Americans who have undiagnosed mental disorders are included, the number may be as high as 15 million, which represents almost 37% of the African American population (Davis, 2005).

Current research suggests that African American men make up a significant proportion of those affected by depression. A national study estimated the lifetime prevalence of depression among African American men to be 7.0%, but the true number may be even higher, as studies have reported that depression is often under-diagnosed in African American patients (Cheung & Snowden, 1990; Whaley, 1997). This poses a significant problem for African American men, especially since depression, if not treated, can lead to suicide (Harris & Barraclough, 1997; U.S. DHHS, 2001; Joe et al., 2006).

Suicide rates among African American men have steadily increased over the last several decades. Between 1950 and 2004, the age-adjusted suicide rate for Black males of all ages has increased by approximately 28%, as compared to a decrease of approximately 14% among comparable White males (U.S. DHHS, 2006). A national study reported that African American men ages 18 years and older have a lifetime prevalence of suicide ideation and suicide attempt of 10.2% and 2.7%, respectively (Joe et al., 2006), and their risk of suicide persists into older adulthood. Even more disconcerting is that African American men who experience suicide ideations and have psychiatric disorders attempt suicide at a significantly higher rate than those without such disorders (Joe et al., 2006). Despite these facts, research and mental health care to address the mental health needs of African American men have failed to keep pace with the prevalence of depression among this group.

The purpose of this paper is to provide a selective review and analysis of literature published since 1985 that has examined depression and mental health among African American men. Using electronic and library searches, the studies reviewed here were found in Academic Search, ERIC, PsycINFO, and PubMed. The literature search resulted in 17 studies that included African American men.

We reviewed this literature with the goals of: 1) highlighting the prevalence of depression among African American men; 2) examining risk factors for depression within this group; 3) examining treatment-seeking and coping behaviors; 4) examining barriers to treatment-seeking; and 5) discussing implications for future research,

mental health care and outreach, with the goal of stimulating interest in addressing depression among African American men.

Prevalence of Depression among African American Men

An estimated 2.6% of African American men ages 18 and over suffered from serious psychological distress between 2003 and 2005; rates for White men of the same age and over the same time period are estimated to be similar, at 2.2% (U.S. DHHS, 2006). Schizophrenia and depression with a focus on suicide are the two mental illnesses experienced by African American men that have received the most attention in the literature.

The National Survey of American Life (NSAL), the largest mental health study of the non-institutionalized Black population ever conducted in the United States, reported that the estimated lifetime prevalence of major depressive disorder (MDD) among African American men was 7.0%, less than half that of White men (16.2%). Despite having a lower lifetime prevalence rate, however, Williams and colleagues (2007) found that the chronicity of MDD for African Americans (56.5%) was greater than for Whites (38.6%), and that African Americans with MDD were more likely to describe their condition as severe or very severe and as causing a greater degree of disability than Whites with MDD. These findings, coupled with the fact that most African Americans (45.0%) with MDD do not receive any treatment, suggest that when African American men develop MDD, the disorder is more debilitating and persistent than it is for White men (Williams et al., 2007).

African Americans are diagnosed with schizophrenia at rates higher than Whites, although this increase may be due, in part, to the under-diagnosis of depression and the over-diagnosis of schizophrenia among African Americans as compared to Whites (Cheung & Snowden, 1990; Whaley, 1997). Cheung and Snowden (1990) reported that schizophrenia diagnosis rates among African Americans were sometimes twice as high as those for Whites, but that Whites were diagnosed with affective disorders (i.e.,

depression) at nearly twice the rate of African Americans. Whaley's (1997) findings suggested that these racial differences in psychiatric diagnoses were due to diagnosticians' misunderstanding of ethnic/racial differences in psychopathology. In any event, the existence of this racial difference in the diagnosis of depression suggests that the prevalence of depression among African American men is likely to be even higher than currently estimated.

Depression, if left untreated, can lead to suicide (Harris & Barraclough, 1997; U.S. DHHS, 2001; Joe et al., 2006). Harris and Barraclough (1997) reported that nearly all mental disorders increase the risk of suicide, and the U.S. Department of Health and Human Services (2001) found that "most people who commit suicide have a mental disorder." A recent study by Joe and colleagues (2006), based on data from the NSAL, found that Black Americans (African Americans and Caribbean Americans) with one or more DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; APA, 1994) disorders were at greater risk for attempting suicide than Blacks with no disorder. Blacks in this study who had any one of the 20 DSM-IV disorders had 8.2 times greater odds and 5 times greater odds, respectively, of developing suicide ideation and attempting suicide compared to those without any mental disorder. The effects of comorbidity were also apparent, as respondents with three or more disorders had 17 and 10 times greater chances, respectively, of suicide attempt and suicide ideation than those with no psychiatric illness. All five of the diagnostic classes of psychiatric disorders assessed (mood disorders, anxiety disorders, substance disorders, childhood disorders, and eating disorders) significantly increased the risk of attempting suicide (Joe et. al., 2006).

The rate of suicide among African American men as a whole has been increasing for the last several decades. Between 1950 and 2004, the age-adjusted suicide rate for African American males of all ages increased by approximately 28% (from 7.5 to 9.6 per 100,000), as compared to a decrease of approximately 14% among comparable White males (22.3 to 19.6 per 100,000) (U.S. DHHS, 2006). Over this same period, suicide rates for African American

men ages 25 to 44 years increased by approximately 28% (from 9.8 to 13.8 per 100,000), ages 65 years and older increased by approximately 26% (from 9.0 to 11.3 per 100,000), while African American men ages 45 to 64 years had a decrease in suicide rates of approximately 20% (from 12.7 to 10.1 per 100,000) (U.S. DHHS, 2006). The overall upward trend in suicide among African American men, however, is mostly due to dramatic increases in suicide rates among young African American men (U.S. DHHS, 2001). The estimated prevalence of attempted suicide among African American males in grades nine through twelve increased from as low as 3.3% in 1991 to as high as 7.7% in 2003 (U.S. DHHS, 2006). The most dramatic increases have occurred among African American men ages 15 to 24, whose rates increased from 4.9 (1950) to 12.2 (2004) per 100,000, reaching as high as 15.1 in 1990 (US DHHS, 2006).

Joe and colleagues (2006) found that until reaching their mid-20s, African American men had substantially lower rates of attempting suicide for the first time compared to African American women, Caribbean American women, and Caribbean American men but that after the age of 34, African American men had the highest risk of attempting suicide of the four sex-by-ethnicity groups under consideration. Moreover, while peaks in the risk of first suicide attempt were exhibited by all four groups, for African American men and African American women the risk of suicide attempt persisted into older adulthood (Joe et al., 2006). The increase in suicide rates among African American men may be an indicator of the prevalence of depression as well as the need for mental health treatment among this population (U.S. DHHS, 2001).

Risk Factors

The onset of depression among African American men is, in part, related to the unique stressors they experience (Rich, 2000). Two such stressors are socioeconomic status (SES) and racial discrimination. SES stressors facing African American men include educational attainment, occupational status, income, and poverty. In 2005, 81.4% of African American men completed high school

or higher, but only 16.1% completed bachelors or higher degrees; the respective educational rates among White men were 89.9% and 32.3% (U.S. Department of Education, 2005).

In 2004, poverty rates among African American men were lowest for those working in management, professional, and related occupations (2.9%) and highest for those working in service occupations (U.S. Department of Labor [U.S. DOL], 2006). However, in 2005 African Americans occupied managerial, professional, and associated positions at lower rates, and service-related positions at higher rates, than their White and Asian counterparts (U.S. DOL, 2005). Based on the 2009 second quarter findings, African American men aged 16 and over who were either full-time wage or salary workers earned $620 in median weekly earnings, which was less than the weekly earnings of White ($842) and Asian American ($909) men (U.S. DOL, 2009). Of the total number of African American men in the U.S. labor force in 2004, 8.4%, approximately 621,000, were estimated to be below the poverty level, a rate nearly two times greater than the rates for their White (4.6%) and Asian (4.7%) counterparts (U.S. DOL, 2006).

Discrimination is another risk factor for depression. Clark and colleagues (1999) reported that perceived racism has a negative effect on the psychological well-being of African Americans. In a recent study examining the association between self-perceived racial discrimination and self-reported mental health, African American men who perceived experiences of discrimination self-reported higher levels of depressive symptoms and significantly lower levels of physical and mental health than their counterparts who did not perceive having experienced discrimination, a finding that remained following adjustments for age, education, and income (Borrell et al., 2006). More specifically, African American men reported worse physical health when they experienced discrimination at work, while discrimination in obtaining medical care was associated with worse mental health. Franklin and Boyd-Franklin (2000) contend that the repeated racial slights that are daily encountered by African American men can negatively affect their psychological well-being

by creating a "psychological invisibility," an intra-psychic process through which Black men come to feel as if they are not persons of worth.

The development of depression in African American men is affected by risk factors occurring during adolescence as well as during adulthood. Using longitudinal data from 892 African American males spanning a 14-year period, Mizell (1999) investigated factors that influence the development of depression in African American men over the life course. He found that low parental achievement (educational attainment, occupational status, social class), low adolescent self-esteem, lesser adult earnings, and low levels of adult mastery (i.e., self-perception of control over their environment) are all contributing factors to higher levels of adult depression for African American males.

Treatment-Seeking and Coping Behaviors

Despite the fact that African American men are burdened by depression, their rates of outpatient mental health service use remain low. A recent national study based on data from the NSAL found that within the last 12 months, only 7.4% of African American men used any type of mental health services in response to problems with emotions, nerves, mental health, or drug or alcohol use (Neighbors et al., 2007). This was lower than the 12-month mental health service use rates for African American women (12.2%), Caribbean American men (11.3%), and Caribbean American women (8.5%). Neighbors and colleagues also reported that among African American men with serious mental disorders, only 50.0% used any type of mental health services.

There is very little research focusing on the coping strategies used by African American men in response to depression. The research that does exist has revealed, however, that although they use mental health services at a low rate, African American men use various strategies to cope with mental health problems. In the National Survey of Black Americans (N = 1,136, 375 males), the

following coping strategies were used most frequently by African American men in response to emotional problems: facing the problem/doing something (85.0%), seeking informal help from family and friends (74.4%), prayer (72.9%), keeping busy (69.9%), trying to relax (69.2%), and trying to forget (63.9%; Broman, 1996). Although drinking or getting high (i.e., using marijuana) was the coping strategy used least frequently in response to emotional problems (18.0%), it was also a strategy that was significantly more likely to be used by African American men than by their female counterparts (Broman, 1996).

Barriers to Treatment-Seeking

Attitudes toward Treatment-Seeking. African American men's treatment-seeking behavior and coping behaviors in response to mental illness are affected by their attitudes towards mental illness and the mental health system. Sussman, Robins, and Earls, (1987) investigated racial differences in the tendency to seek treatment for depression, and found African Americans compared to Whites were more likely to avoid seeking care due to distrust of treatment and fear of being hospitalized. Similarly, Ward and Besson (2009, August) found that African Americans men believed that having a mental illness can result in negative outcomes such as being hospitalized or placement in corrections.

While not specific to mental health, a focus group study reported that distrust of physicians among African American patients was due to several factors, including a lack of interpersonal competence, lack of technical competence, perceived greed, racism, and beliefs about experimentation (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). Trusting relationships between physicians and Black patients encouraged openness, honesty, and adherence to treatment recommendations, while distrust was associated with lack of adherence, avoidance of care, and even withdrawal from care (Jacobs, Rolle, Ferrans, Whitaker, Warnecke, 2006). Consistent with these findings, Whaley (2004) suggested that mental health professionals' cultural biases and negative stereotypes about Black

men may have caused the poor treatment-seeking behavior and mistrust of the mental health system exhibited by African American men.

Despite the low use of mental health services among African Americans, the National Comorbidity Survey (NCS) revealed that prior to utilization of mental health services, the attitudes of African Americans toward seeking such services was more positive than that of Whites; these attitudes included inclination to seek care, level of comfort with seeking care, and level of comfort with friends knowing they were seeking professional care. These findings held true for African Americans in the general population as well as those diagnosed with major depression. After receiving mental health services, however, African Americans were more likely than Whites to have negative attitudes about such services, displaying decreased odds of going back to receive further services due to continued illness, as well as decreased comfort with friends knowing that they sought professional care (Diala et al., 2000).

Stigma

The stigma associated with mental illness is another barrier to obtaining treatment among African American men. The Surgeon General's report on mental health recognized stigma related to the receipt of mental health services as one of the foremost causes of underutilization, particularly among racial minority groups (U.S. DHHS, 2001). A recent qualitative study revealed that African Americans harbored stigmas about persons with mental illness and that these beliefs negatively influenced their mental illness treatment-seeking behaviors (Sanders Thompson, Bazile, & Akbar, 2004). Research suggests that African Americans hold more negative attitudes about mental illness than Whites (Cooper-Patrick, Powe, & Jenckes, 1997; Silva de Crane & Spielberger, 1981). Other studies posit that African Americans are more likely than Caucasians to perceive individuals with mental illness as dangerous, that is, as persons who would commit violent acts against others (Whaley, 1997; Anglin, Link, & Phelan, 2006). In a nationally representative

study, Whaley (1997) found that the perception of dangerousness held by African Americans towards mentally ill individuals persisted even when their contact with mentally ill people was increased. Increased contact with mentally ill individuals was, however, associated with reduced stigma among Whites (Whaley, 1997). While African Americans were significantly more likely than Caucasians to view mentally ill individuals as dangerous, the belief that individuals with mental illness should be blamed or punished for their violent behavior was significantly less likely to be held by African Americans than by their Caucasian counterparts, a finding that persisted after controlling for socio-demographic factors (Anglin, Link, & Phelan, 2006).

In summary, African American men are burdened by mental illness, particularly depression, and this burden may in part contribute to the dramatic increase in suicide rates among this population. Risk factors for the development of depression among African American men include socioeconomic status, racial discrimination, low parental achievement, low adolescent self-esteem, and low levels of adult mastery. African American men's rate of outpatient mental health care remains low in part due to distrust, fear of hospitalization, and the stigma associated with mental illness. It appears that African American men tend to use informal support networks, prayer and avoidance strategies to cope with depression.

Directions for Future Research, Practice, and Community Outreach

Research

In order to better address the mental health needs of African American men, more research is needed, particularly research focused on developing and empirically validating culturally-specific interventions to treat mental illness, especially depression, and ameliorate modifiable risk factors. For example, some of the interventions/programs needed are culturally-specific career guidance/counseling, job skill training, and healthy coping strategies

for dealing with racism and discrimination. There is also a need for epidemiological research to clarify the prevalence of specific mental disorders among African American men. In general, there needs to be greater inclusion of African American men in health research in an effort to eliminate racial disparities in health and health care and improve the quality of life for African American men.

Mental Health Care

Due to concerns about misdiagnosis of African American men (Cheung & Snowden, 1990; Whaley, 1997), it is imperative that health care systems and providers are culturally competent. Betancourt, Green, and Carrillo (2002) describe cultural competence in health care as "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (p. v.). Betancourt et al. (2002) suggest that cultural competence in health care can support quality improvement and eliminate racial/ethnic disparities in health care and health.

Recognizing the positive outcomes associated with cultural competence in mental health care, training mental health clinicians to provide culturally competent care is vital. Cultural competence training must be systematically implemented early in the education process in psychology programs, using an integrated approach that incorporates cultural competence into each course. In addition, professional development training for mental health professionals should include a cultural competence focus.

Community Outreach

Given African American men's low use of mental health services, which is related to access-related barriers and the high prevalence of stigma in the African American community, more community outreach tailored specifically for African American men is needed. In particular, outreach should focus on educating African American men about mental illness, the health outcomes of having an untreated mental illness, and treatment options. In addition, community outreach should provide information about community mental health and other social services agencies that provide services on a sliding scale to help reduce access-related barriers.

Research suggest that although African American men use diverse strategies to cope with mental illness, praying and seeking support from informal networks appear to be used most frequently (Broman, 1996). Therefore, community outreach that is family-centered and conducted in collaboration with African American churches and neighborhood groups may be particularly helpful for Black men. These community outreach strategies can be beneficial to this group by increasing access, reducing stigma associated with mental illness and facilitating early treatment-seeking.

Conclusion

This selective review of the literature provides evidence suggesting that depression among African American men is quickly approaching a public health crisis. African American men experience numerous risk factors for depression, and their rate of mental health service use is low. When they do seek services, they are under-diagnosed with depression but over-diagnosed with schizophrenia. In addition, the suicide rate among African American men is increasing. Despite the heavy burden of depression among African American men, research focusing on addressing the needs of this group is scarce. There is a need for more health-related research focusing specifically on African American men. In addition, mental health care provided to this population needs to be culturally sensitive. Finally, outreach to the African American community can help reduce access barriers and the stigma associated with mental illness, and increase early treatment-seeking.

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